Medicare Claims Processing Manual
Chapter 14 - Ambulatory Surgical Centers

Table of Contents
(Rev. 975, 06-09-06)

10 - General

(Rev. 1, 10-01-03)

B3-2265

Payment is made under Part B for certain surgical procedures that are furnished in ASCs and are approved for being furnished in an ASC. These procedures are those that generally do not exceed 90 minutes in length and do not require more than four hours recovery or convalescent time.

To be paid under this provision, a facility must be certified as meeting the requirements for an ASC and must enter into a written agreement with the Centers for Medicare & Medicaid Services (CMS). The certification process is described in the State Operations Manual.

Medicare will not pay an ASC for those procedures that require more than an ASC level of care, or for minor procedures that are normally performed in a physician's office.

The CMS publishes updates to the list of procedures for which an ASC may be paid each year. The complete list of procedures is available through the Public Use files (PUF) at http://www.cms.hhs.gov/researchers/. This includes applicable codes, payment groups, and payment amounts for each ASC group before adjustments for regional wage variations. Applicable wage indices are also published via program memorandum.

ASCs must accept Medicare's payment for such procedures as payment in full for the facility service with respect to those services defined as ASC facility services. The physician and anesthesiologist may bill and be paid for the professional component of the service also.

Certain other services may be performed in an ASC facility, billed by the appropriate certified provider/supplier, or in certain cases by the ASC facility itself, and paid outside of the facility rate.

10.1 - Definition of Ambulatory Surgical Center (ASC)

(Rev. 1, 10-01-03)

B3-2265.1

An ASC for Medicare purposes is a distinct entity that operates exclusively for the purpose of furnishing outpatient surgical services to patients. The ASC must enter into a "participating provider" agreement with CMS. An ASC is either independent (i.e., not a part of a provider of services or any other facility), or operated by a hospital (i.e., under the common ownership, licensure or control of a hospital). If an ASC is the latter type, it has the option either of being covered under Medicare as an ASC, or of continuing to be covered as a hospital-affiliated outpatient surgery department as such entities were covered prior to the enactment of ASC legislation on December 5, 1980. To be covered as an ASC operated by a hospital, a facility:

- Elects to do so, and continues to be so covered unless CMS determines there is good cause to do otherwise;

- Is a separately identifiable entity, physically, administratively, and financially independent and distinct from other operations of the hospital with costs for the ASC treated as a non-reimbursable cost center on the hospital's cost report;
- Meets all the requirements with regard to health and safety, and agrees to the assignment, coverage and payment rules applied to independent ASCs; and
- Is surveyed and approved as complying with the conditions for coverage for ASCs in 42 CFR 416.40-49.

Related survey requirements are published in the State Operations Manual.

If a facility meets the above requirements, it bills the carrier on Form CMS-1500 or the related electronic data set and is paid the ASC payment amount.

If a hospital based facility decides not to become a certified ASC it bills the fiscal intermediary (FI) on Form CMS-1450 or the related EDI data set and is subject to hospital outpatient billing and payment rules. It is also subject to hospital outpatient certification and participation requirements.

10.2 - Ambulatory Surgical Center Services on ASC List

(Rev. 914, Issued: 04-21-06; Effective: 02-27-06; Implementation: 05-22-06)

ASC services are those surgical procedures that are identified by CMS on an annually updated ASC listing. Some medical services covered by Medicare are not on the list. These may be billed by the rendering provider as Part B services but not as ASC services.

The ASC payment rate includes only the specific ASC services. All other non-ASC services such as physician services, prosthetic devices, may be covered and separately billable under Medicare Part B. The Medicare definition of covered facility services includes services that would be covered if furnished on an inpatient or outpatient basis in connection with a covered surgical procedure. This includes operating and recovery rooms, patient preparation areas, waiting rooms, and other areas used by the patient or offered for use to patients needing surgical procedures. It includes all services and procedures in connection with covered procedures furnished by nurses, technical personnel and others involved in patient care. These do not include physician services, or medical and other health services for which payment may be made under other Medicare provisions (e.g., services of an independent laboratory located on the same site as the ASC, prosthetic devices other than intraocular lenses (IOLs), anesthetist services, DME).

Carriers are not concerned with whether a given item or service is a covered ASC facility service, unless the ASC makes a separate charge for it. Where a separate charge is made the carrier must determine whether the item or service falls into the categories described in the following section. If the item or service falls into one of those categories, payment is made following the applicable rules for such items and services found elsewhere in this chapter. If the item or service does not fall into one of the categories described, the claim is denied.

Examples of covered ASC facility services include:

- Nursing services, services of technical personnel, and other related services;
- The use by the patient of the ASC facilities;

- Drugs, biologicals, surgical dressings, supplies, splints, casts, appliances, and equipment;
- Diagnostic or therapeutic items and services;
- Administrative, recordkeeping, and housekeeping items and services;
- Blood, blood plasma, platelets, etc., except for those to which the blood deductible applies;
- Materials for anesthesia; and
- Intraocular lenses (IOLs) except for new technology IOLs (NTIOLs) (refer to 42 CFR 416.180-200).

Nursing Services, Services of Technical Personnel, and Other Related Services

These include all services in connection with covered procedures furnished by nurses and technical personnel who are employees of the ASC. In addition to the nursing staff, this category includes orderlies, technical personnel, and others involved in patient care.

Use by the Patient of the ASC Facilities

This category includes operating and recovery rooms, patient preparation areas, waiting rooms, and other areas used by the patient or offered for use by the patient's relatives in connection with surgical services.

Drugs, Biologicals, Surgical Dressings, Supplies, Splints, Casts, Appliances, and Equipment

This category includes all supplies and equipment commonly furnished by the ASC in connection with surgical procedures. See the following paragraphs for certain exceptions. Drugs and biologicals are limited to those which cannot be self-administered. See the Medicare Benefit Policy Manual, Chapter 15, §50.2, for a description of how to determine whether drugs can be self-administered.

Under Part B, coverage for surgical dressings is limited to primary dressings, i.e., therapeutic and protective coverings applied directly to lesions on the skin or on openings to the skin required as the result of surgical procedures. (Items such as Ace bandages, elastic stockings and support hose, Spence boots and other foot coverings, leotards, knee supports, surgical leggings, gauntlets and pressure garments for the arms and hands are used as secondary coverings and therefore are not covered as surgical dressings.) Although surgical dressings usually are covered as "incident to" a physician's service in a physician's office setting, in the ASC setting, such dressings are included in the facility's services.

However, surgical dressings may be reapplied later by others, including the patient or a member of his family. When surgical dressings are obtained by the patient on a physician's order from a supplier, e.g., a drugstore, the surgical dressing is covered under Part B. The same policy applies in the case of dressings obtained by the patient on a physician's order following surgery in an ASC; the dressings are covered and paid as a Part B service by the DMERC.

Similarly, “other supplies, splints, and casts” include only those furnished by the ASC at the time of the surgery. Additional covered supplies and materials furnished later are generally furnished as “incident to” a physician’s service, not as an ASC facility service. The term “supplies” includes those required for both the patient and ASC personnel, e.g., gowns, masks, drapes, hoses, and scalpels, whether disposable or reusable. These are included in the rate for the service (HCPCS code).

Diagnostic or Therapeutic Items and Services

These are items and services furnished by ASC staff in connection with covered surgical procedures. Many ASCs perform diagnostic tests prior to surgery that are generally included in the facility charges, such as urinalysis, blood hemoglobin, hematocrit levels, etc. To the extent that such simple tests are included in the ASC facility charges, they are considered facility services. However, under the Medicare program, diagnostic tests are not covered in laboratories independent of a physician’s office, rural health clinic, or hospital unless the laboratories meet the regulatory requirements for the conditions for coverage of services of independent laboratories. (See 42 CFR 405.1310) Therefore, diagnostic tests performed by the ASC other than those generally included in the facility’s charge are not covered under Part B and are not to be billed as diagnostic tests. If the ASC has its laboratory certified, the laboratory itself may bill for the tests performed.

The ASC may make arrangements with an independent laboratory or other laboratory, such as a hospital laboratory, to perform diagnostic tests it requires prior to surgery. In general, however, the necessary laboratory tests are done outside the ASC prior to scheduling of surgery, since the test results often determine whether the beneficiary should have the surgery done on an outpatient basis in the first place.

Administrative, Recordkeeping and Housekeeping Items and Services

These include the general administrative functions necessary to run the facility e.g., scheduling, cleaning, utilities, and rent.

Blood, Blood Plasma, Platelets, etc., Except Those to Which Blood Deductible Applies

While covered procedures are limited to those not expected to result in extensive loss of blood, in some cases, blood or blood products are required. Usually the blood deductible results in no expenses for blood or blood products being included under this provision. However, where there is a need for blood or blood products beyond the deductible, they are considered ASC facility services and no separate charge is permitted to the beneficiary or the program.

Materials for Anesthesia

These include the anesthetic itself, and any materials, whether disposable or re-usable, necessary for its administration.

Intraocular Lenses (IOLs) and New Technology IOLs (NTIOLs)

The ASC facility services include IOLs (effective for services furnished on or after March 12, 1990), and NTIOLs (effective for services furnished on or after May 18,

2000), approved by the Food and Drug Administration (FDA) for insertion during or subsequent to cataract surgery.

FDA has classified IOLs into the following categories, any of which are included:

1. Anterior chamber angle fixation lenses;
2. Iris fixation lenses;
3. Irido-capsular fixation lenses; and
4. Posterior chamber lenses.
5. NTIOL Category 1 (as defined in "Federal Register" Notice, VOL 65, dated May 3, 2000). Note: This category expired May 18, 2005
6. NTIOL Category 2 (as defined in "Federal Register" Notice, VOL 65, dated May 3, 2000). Note: This category expired May 18, 2005
7. NTIOL Category 3 (as defined in Federal Register Notice, 71 FR 4586, dated January 27, 2006): This category will expire on February 26, 2011.

Note that while generally no separate charges for intraocular lenses (IOLs) are allowed, approved NTIOLS may be billed separately in addition to the facility rate. (See §40.3.)

10.3 - Services Furnished in ASCs Which Are Not *ASC Facility Services*

(Rev. 975, Issued: 06-09-06, Effective: 06-05-06, Implementation: 06-05-06)

A single payment is made to an ASC, which includes all "facility services" furnished by the ASC in connection with a covered procedure. However, a number of items and services covered under Medicare may be furnished in an ASC which are not considered facility services, and which the ASC payment does not include. These non-ASC services are covered and paid for under the applicable provisions of Part B. In addition, the ASC may be part of a medical complex that includes other entities, such as an independent laboratory, supplier of durable medical equipment, or a physician's office, which are covered as separate entities under Part B. In general, an item or service provided in a separate part of the complex is not considered an ASC service, except as defined above.

Examples of *payment and billing* for items or services that are not ASC facility services

Items not included in the ASC facility rate	***Who may receive payment***	***Submit bills to:***
Physicians' services	Physician	*Carrier*
The purchase or rental of *non-implantable* durable medical equipment (*DME)* to ASC patients for use in their homes.	*Supplier- An ASC can be a supplier of DME if it has a supplier number from the National Supplier Clearinghouse.*	*DMERC*
Implantable DME and accessories	*ASC*	*Carrier*

Items not included in the ASC facility rate	***Who may receive payment***	***Submit bills to:***
Non-implantable prosthetic devices	*Supplier. An ASC can be a supplier of non-implantable prosthetics if it has a supplier number from the National Supplier Clearinghouse.*	*DMERC*
Implantable prosthetic devices except intraocular lenses (IOLs and NTIOLs), and accessories	*ASC*	*Carrier*
Ambulance services	Certified Ambulance supplier	*Carrier*
Leg, arm, back and neck braces	Supplier	*DMERC*
Artificial legs, arms, and eyes	Supplier	*DMERC*
Services furnished by an independent laboratory	*C*ertified lab. ASCs can receive lab certification and a CLIA number.	*Carrier*
Procedures NOT on the ASC list	*Physician*	*Physician bills Carrier for procedure and any implantable prosthetics/DME using the ASC as the place of service. See Pub. 100-04, Chapter 12, section 20.4*

10.4 - Coverage of Services in ASCs Which Are Not *ASC Facility Services*

(Rev. 975, Issued: 06-09-06, Effective: 06-05-06, Implementation: 06-05-06)

Physicians' Services - This category includes most covered services performed in ASCs which are not considered ASC facility services. Consequently, physicians who perform covered services in ASCs receive separate payment under Part B. Physicians' services include the services of anesthesiologists administering or supervising the administration of anesthesia to ASC patients and the patients' recovery from the anesthesia. The term physicians' services also includes any routine pre- or post- operative services, such as office visits, consultations, diagnostic tests, removal of stitches, changing of dressings, and other services which the individual physician usually includes in the fee for a given surgical procedure.

Durable Medical Equipment (DME) - If the ASC furnishes items of DME to patients, it is treated as a DME supplier, and all the rules and conditions ordinarily applicable to DME are applicable, including obtaining a supplier number and billing the DMERC where applicable.

If the ASC furnishes items of implantable DME to patients, the ASC bills the local Carrier for the surgical procedure and the implantable device and receives payment from the local Carrier for those items. When the surgical procedure is not on the ASC list, the physician bills the Carrier for both the surgical procedure and the implanted device, coding the ASC as the place of service on the bill (See Pub. 100-04, Chapter 12, section 20.4).

Prosthetic Devices –*An ASC may bill and receive separate payment for* prosthetic devices, other than intraocular lenses (IOLs) that *are* implanted, inserted, or otherwise applied by surgical procedures *on the ASC list of approved procedures. The ASC bills the local Carrier and receives payment according to the DMEPOS fee schedule*. However, an intraocular lens (IOL) inserted during or subsequent to cataract surgery in an ASC is included in the facility payment rate.

If the ASC furnishes *other non-implantable* prosthetic devices to patients, the ASC is treated as a supplier, and all the rules and conditions ordinarily applicable to suppliers are applicable, including obtaining a supplier number and billing the DMERC where applicable.

Ambulance Services - If the ASC furnishes ambulance services, the facility may obtain approval as an ambulance supplier to bill covered ambulance services.

Leg, Arm, Back and Neck Braces - These items of equipment, like prosthetic devices, are covered under Part B, but are not included in the ASC facility payment amount. If the ASC furnishes these to patients, it is treated as a supplier, and all the rules and conditions ordinarily applicable to suppliers are applicable, including obtaining a supplier number and billing the DMERC where applicable.

Artificial Legs, Arms and Eyes - Like prosthetic devices and braces, this equipment is not considered part of an ASC facility service and so is not included in the ASC facility payment rate. If the ASC furnishes these items to patients, it is treated as a supplier, and all the rules and conditions ordinarily applicable to suppliers are applicable, including obtaining a supplier number and billing the DMERC where applicable.

Services of Independent Laboratory - As noted in §10.2, only a very limited number and type of diagnostic tests are considered ASC facility services and these are included in the ASC facility payment rate. In most cases, diagnostic tests performed directly by an ASC are not only not considered ASC facility services, but are not covered under Medicare since §1861(s) of the statute limits coverage of diagnostic lab tests in facilities other than physicians' offices, rural health clinics or hospitals to facilities that meet the statutory definition of an independent laboratory. The ASC's laboratory must be CLIA certified and will need to enroll with the carrier as a laboratory. Otherwise, the ASC makes arrangements with a covered laboratory or laboratories for laboratory services, as provided in 42 CFR 416.49. If the ASC has a certified independent laboratory, the laboratory itself bills the carrier.

20 - List of Covered Ambulatory Surgical Center Procedures

(Rev. 1, 10-01-03)

B3-2266, PM AB 01 121, PM AB 01 141

The CMS issues its public use file for ASCs each year to update the list of procedures for which an ASC may be paid. This file can be obtained at http://www.cms.hhs.gov/researchers/. Updates may be made during the year as needed, e.g., if a new HCPCS code is established. The program memo includes applicable codes, payment groups, and payment amounts for each ASC group before adjustments for regional wage variations. Applicable wage indices are also published annually.

20.1 - Nature and Applicability of ASC List

(Rev. 1, 10-01-03)

B3-2266.1

The list of covered procedures merely indicates procedures which are covered and paid for if performed in the ASC setting. It does not require such procedures to be performed in such settings. The choice of a location to operate is a decision of the patient's physician. Also, all the general coverage rules regarding the appropriateness of a given procedure for a given patient are applicable to ASC services in the same manner as all other covered services.

20.2 - Types of Services Included on the List

(Rev. 1, 10-01-03)

B3-2266.2

The Medicare approved procedures are all considered "surgical procedures" for purposes of ASC coverage, regardless of the use of the procedure. For example, many of the "oscopy" procedures listed - bronchoscopy, laryngoscopy, etc., may be employed for either diagnostic or therapeutic purposes, or even both at the same time, such as when the "oscopy" permits both detection and removal of a polyp. Those procedures are considered "surgical procedures" within the context of the ASC provision. Also, surgical procedures are commonly thought of as those involving an incision of some type, whether done with a scalpel or (more recently) a laser, followed by removal or repair of an organ or other tissue. In recent years, the development of fiber optics technology, together with new surgical instruments using that technology, has resulted in surgical procedures that, while invasive and manipulative, do not require incisions. Instead, the procedures are performed without an incision through various body openings. Those procedures, some of which include the "oscopy" procedures mentioned above, are also considered surgical procedures for purposes of the ASC provision, and several are included in the list of covered procedures.

20.3 - Rebundling of CPT Codes

(Rev. 1, 10-01-03)

B3-2266.3

The general CCI rebundling instructions apply to processing claims from ASC facilities services. In general, if an ASC bills a CPT code that is considered to be part of another more comprehensive code that is also billed for the same beneficiary on the same date of service, only the more comprehensive code is covered, provided that code is on the list of ASC approved codes.

Refer to Chapter 23 for a description of these instructions.

30 - Rate-Setting Policies

(Rev. 1, 10-01-03)

B3-5243.1

Generally, there are two primary elements in the total cost of performing a surgical procedure:

- The cost of the physician's professional services for the performing the procedure; and
- The cost of services furnished by the facility where the procedure is performed (for example, surgical supplies and equipment and nursing services).

The professional fee is paid to the physician; the facility fee is paid to the ASC.

The ASC payment rate is a standard overhead amount established on the basis of CMS's estimate of a fair fee and the costs incurred by the ASCs providing the procedure. To estimate this cost, the CMS surveys audit costs incurred by a sample of ASCs. In order to estimate the amount of those reasonable allowances, CMS surveys the actual audited costs incurred by a representative sample of ASCs. This survey is conducted every five years. The CMS also consults with appropriate trade and professional organizations in specifying the procedures that comprise the ASC list.

There is an adjustment for inflation during fiscal years when ASC rates are not updated based on actual audited costs determined by surveying a representative sample of facilities. Also ASC payment rates are increased by the percentage increase in the consumer price index for urban consumers (CPI-U), as estimated by the Secretary for the 12-month period ending with the midpoint of the year involved, reduced by 2 percentage points (but not less than 0) for fiscal years 1998 - 2002.

30.1 - Where to Obtain Current Rates and List of Covered Services

(Rev. 1, 10-01-03)

The CMS performs the functions and calculations described above and publishes a list of procedures for which an ASC may be paid each year, including intra-year updates as needed, via Medicare temporary instructions. This includes applicable codes, payment groups, and payment amounts for each ASC group before adjustments for regional wage variations. Applicable wage indices that must be used to adjust payment for regional wage variations are also published via temporary instructions.

Regulations pertaining to Medicare rates for ASC facility services are contained in Part 416 of the Code of Federal Regulations, (42 CFR 416.)

ASC facility services are subject to the usual Medicare Part B deductible and coinsurance requirements.

The ASC facility fees are based on a prospectively determined rate that CMS estimates will approximate the costs incurred by ASCs generally in providing covered facility services. As of the date this instruction was written, HCPCS procedures for services covered by the ASC are grouped into 9 groups and a rate is set for each group. The

number of such groups may change in subsequent CMS temporary instructions dealing with ASC facility fees. CMS informs carriers and intermediaries of new rates in a one time instruction whenever rate changes occur.

40 - Payment for Ambulatory Surgery

(Rev. 1, 10-01-03)

B3-5243

40.1 - Payment to Ambulatory Surgical Centers for Non-ASC Services

(Rev. 1, 10-01-03)

B3-5243.1

ASCs may furnish and be paid under other parts of Medicare Part B for services that are not considered ASC facility services. The usual Part B coverage and payment rules apply to such services.

40.2 - Carrier Adjustment of Base Payment Rates

(Rev. 1, 10-01-03)

B3-5243.2

The payment rates established for the groups of ASC procedures (see §30) are standard base rates that have been adjusted to remove the effects of regional wage variations. When carriers process claims for ASC facility services, they adjust the base rates to reflect the wage index value applicable to the area in which the ASC is located. The Medicare payment for ASC facility services is equal to 80 percent of the wage-adjusted standard payment rate. Beneficiaries are responsible for a 20 percent copayment for ASC facility services once their deductible is satisfied.

The wage index includes the wage and salary levels of certain health care professionals in both urban and nonurban locations, compared to a national norm of 1.0. Areas with above average wage levels have index numbers greater than 1.0, while areas with below average wage levels have index numbers below l.0.

Each MSA within a State has a separate index, and there is one index for all rural areas within a State.

Also each group's payment rate has a labor and a nonlabor component, and only the labor component is adjusted for the wage index.

Carriers must adjust ASC payment rates by following these steps. Carriers round calculations to the fourth decimal place at each step.

1. Separate each group's payment rate into its labor (.3445) and nonlabor (.6555) components. To determine the payment rate that is subject to the labor adjustment for Group 6 and Group 8, first subtract the IOL allowance from each group's composite payment rate. (This is because IOLs are not subject to adjustment for labor costs, therefore the IOL allowance must be subtracted from the composite payment rate before applying the wage index adjustment, and then added back in the calculation as described in step 5).

2. Identify the appropriate wage index value for the ASC's location.

3. Multiply the labor component (payment rate multiplied by .3445 - Step 1) by the appropriate wage index value.

4. Add the adjusted labor component (Step 3) to the nonlabor component (payment rate multiplied by .6555 - Step 1) to determine the total adjusted payment rate.

5. For Groups 6 and 8, add the IOL allowance to the total adjusted payment rate (Step 4) to determine the total adjusted composite rate for the procedures in these groups.

This provides the ASC payment rate for the ASC. Round the final amount to the nearest dollar.

Note that coinsurance (and deductible if applicable) is deducted from the payment amount.

EXAMPLE 1:

This example shows how to determine payment for an ASC with a wage index value of 1.0985 for a procedure in payment group 4 ($612). The labor related portion is 34.45 percent and the nonlabor related portion is 65.55 percent.

Use the steps illustrated in Example 1 to adjust payment rates for groups whose payment rate does not include an allowance for an IOL.

Wage Adjusted Rate

= (($612 x .3445) x 1.0985) + ($612 x 0.6555)

= ($210.83 x 1.0985) + $401.17

= $231.60 + $401.17

= $632.77

Final Payment

= $632.77 x .80

= $506.21

EXAMPLE 2:

The following shows how to determine payment to an ASC for services furnished in January 2002 with a wage index value of 1.0714, for each of the two procedures in Group 8 ($949). Use the steps in this example to calculate payment amounts for each of the two procedures in Group 6 as well. Subtract $150 (the IOL allowance) from the composite payment rate ($949 for Group 8 and $806 for Group 6) before adjusting for wage variation.

Wage Adjusted Rate

= [(($949 - $150) x 0.3455) x 1.0714] + [($949 - $150) x 0.6555]

= [($799 x 0.3455) x 1.0714] + ($799 x 0.6555)

= ($276.05 x 1.0714) + $523.74

= $295.76 + $523.74

= $819.51

Composite Adjusted Rate

= $819.51 + $150

= $969.51

Final Payment

= $969.51 x .80

= $775.61

40.3 - Payment for Intraocular Lens (IOL)

(Rev. 914, Issued: 04-21-06; Effective: 02-27-06; Implementation: 05-22-06)

Payment for facility services furnished by an ASC for IOL insertion during or subsequent to cataract surgery includes an allowance for the lens. The procedures that include insertion of an IOL are:

Payment Group 6: CPT-4 Codes 66985 and 66986

Payment Group 8: CPT-4 Codes 66982, 66983 and 66984

Do not pay physicians or suppliers for an IOL furnished to a beneficiary in an ASC after July 1, 1988. Deny separate claims for IOLs furnished to ASC patients beginning March 12, 1990. Also, effective March 12, 1990, procedures 66983 and 66984 are treated as single procedures for payment purposes.

Refer to 42 CFR 416.185 for discussion of New Technology Intraocular Lenses (NTIOLs). While the carrier claims processing systems allow no separate charges for conventional intraocular lenses (IOLs), the cost of the IOL is bundled into the ASC facility fee, NTIOLs may be billed separately in addition to the facility fee. Medicare pays an additional $50 on the following NTIOLs Q1001 (Category 1, Model AMO Array Multifocal lens) and Q1002 (Category 2, Model Elastic Ultraviolet-Absorbing Silicone Posterior Chamber Lens) when billed for dates of service from May 18, 2000 through May 18, 2005. However, effective for dates of service on and after May 19, 2005, Medicare will no longer reimburse the additional $50 and these two codes will be invalid for Medicare.

Effective for dates of service on and after February 27, 2006, through February 26, 2011, Medicare will pay an additional $50 for NTIOL [Category 3(Reduced Spherical Aberration), Model Advanced Medical Optics (AMO) Tecnis® IOL model numbers Z9000, Z9001, and ZA9003]. HCPCS code Q1003 has been created to bill for the additional $50. Q1003 shall be billed on the same claim as the surgical insertion procedure.

Any subsequent IOLs recognized by CMS as having the same characteristics as the first IOL recognized by CMS for a payment adjustment (those of reduced spherical aberration) will receive the same adjustment for the remainder of the 5-year period established by the first recognized IOL. Contractors and providers will be aware that HCPCS Q1003, along with one of the approved procedures codes (66982, 66983, 66984, 66985, 66986) are to be used on all NTIOL Category 3 claims associated with reduced

spherical aberration from February 27, 2006, through February 26, 2011. See: http://www.cms.hhs.gov/CoverageGenInfo/downloads/AppforcurrentNTIOL.subset.pdf. Additionally, contractors may obtain information on Medicare-approved NTIOLs at: http://www.cms.hhs.gov/center/coverage.asp.

Medicare Summary Notice (MSN) and Claims Adjustment Reason Codes

Carriers shall return as unprocessable any claims for NTIOLs containing Q1003 alone or with a code other than one of the above listed procedure codes. Use the following messages for these returned claims:

- Claim Adjustment Reason Code 16 - Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remark codes whenever appropriate.
- RA Remark Code M67 - Missing/Incomplete/Invalid other procedure codes.
- RA Remark Code MA130 - Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.

Carriers shall deny payment for Q1003 if services are furnished in a facility other than a Medicare-approved ASC. Use the following messages when denying these claims:

- MSN 16.2 - This service cannot be paid when provided in this location/facility.
- Claims Adjustment Reason Code 58 - Payment adjusted because treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service.

Carriers shall deny payment for Q1003 if **billed** by an entity other than a Medicare-approved ASC. Use the following messages when denying these claims:

- MSN 33.1 - The ambulatory surgical center must bill for this service.
- Claim Adjustment Reason Code 170 - Payment is denied when performed/billed by this type of provider.

Carriers shall deny payment for Q1003 if submitted for payment past the discontinued date (after the 5-year period, or after February 26, 2011). Use the following messages when denying these claims:

- MSN 21.11 - This service was not covered by Medicare at the time you received it.
- Claim Adjustment Reason Code 27 - Expenses incurred after coverage terminated.

40.4 - Payment for Terminated Procedures

(Rev. 1, 10-01-03)

B3-5243.4

The following criteria determine the appropriate ASC facility payment for a scheduled surgical procedure that is terminated due to medical complications which increase the

surgical risk to the patient. Carriers may pay a different rate percentage in certain situations where documentation supports such action.

A. Carriers deny payment when an ASC submits a claim for a procedure that is terminated either for nonmedical or medical reasons before the ASC has expended substantial resources. For example, payment is denied if scheduled surgery is canceled or postponed because the patient on intake complains of a cold or flu.

B. Carriers pay 50 percent of the rate if a surgical procedure is terminated due to the onset of medical complications after the patient has been prepared for surgery and taken to the operating room but before anesthesia has been induced (use modifier 73). For example, 50 percent is paid if the patient develops an allergic reaction to a drug administered by the ASC prior to surgery or if, upon injection of a retrobulbar block, the patient experiences a retrobulbar hemorrhage which prevents continuation of the procedure. Although some supplies and resources are expended, they are not consumed to the same extent had anesthesia been fully induced and the surgery completed. Carriers may pay a different percentage of the rate if, in an individual case, documentation supports such action. Carriers use a 73 modifier to indicate that the procedure terminated prior to induction of anesthesia.

C. Carriers make full payment of the facility rate if a medical complication arises which causes the procedure to be terminated after inducement of the anesthetic agent (use modifier -74). For example, carriers make full payment if, after anesthesia has been accomplished and the surgeon has made a preliminary incision, the patient's blood pressure increases suddenly and the surgery is terminated to avoid increasing surgical risk to the patient. In this case, the resources of the facility are consumed in essentially the same manner and to the same extent as they would have been had the surgery been completed. Carriers use a 74 modifier to indicate that the procedure terminated after inducement of anesthetic agent

D. Carriers deduct the allowance for an unused IOL prior to calculating payment for a terminated IOL insertion procedure.

An ASC claim for payment for terminated surgery must be accompanied by an operative report that specifies the following:

- Reason for termination of surgery;
- Services actually performed;
- Supplies actually provided;
- Services not performed that would have been performed if surgery had not been terminated;
- Supplies not provided that would have been provided if the surgery had not been terminated;
- Time actually spent in each stage, e.g., pre-operative, operative, and post-operative;
- Time that would have been spent in each of these stages if the surgery had not been terminated; and

- CPT-4 code for procedure had the surgery been performed.

40.5 - Payment for Multiple Procedures

(Rev. 1, 10-01-03)

B3-5243.5

Each surgical procedure has its own CPT-4 code. When more than one surgical procedure is performed in the same operative session, special payment rules apply even if the services have the same CPT-4 code number.

When the ASC performs multiple procedures in the same operative session, carriers base the ASC facility payment upon the wage adjusted rate of the procedure in the highest payment group, plus 50 percent of the applicable wage adjusted rate for the next highest ASC covered procedure(s) furnished in the same session. For example, if a Group 1, a Group 2, and a Group 3 procedure are all performed in the same operative session, base the ASC payment on 100 percent of the wage adjusted Group 3 rate plus 50 percent of the wage adjusted Group 1 rate, plus 50 percent of the wage adjusted Group 2 rate. If more than one procedure in the same payment group is performed, pay the full wage adjusted rate for one of the procedures and 50 percent of the wage adjusted rate for the remaining procedure(s).

In both of these examples, final payment is subject to the usual copayment and deductible provisions.

If CPT-4 codes 66985 or 66986, Group 6 procedures, are performed in the same operative session that a Group 7 procedure is performed, apply the 50 percent multiple procedure reduction to the wage adjusted portion of the Group 6 rate (i.e., the Group 6 payment amount minus the amount of the IOL add-on). Pay the full IOL allowance amount.

A procedure performed bilaterally in one operative session is reported as two procedures. Therefore, treat payment for a procedure performed bilaterally the same as payment for multiple procedures. For example, if sinusotomy, maxillary (antrotomy); intranasal (CPT-4 code 31020) is performed bilaterally in one operative session, report it as CPT-4 code 31020 performed two times. Calculate payment for bilateral procedures by multiplying the appropriate wage adjusted payment amount by 150 percent.

40.6 - Payment for Extracorporeal Shock Wave Lithotripsy (ESWL)

(Rev. 1, 10-01-03)

B3-5243.6

A ninth ASC payment group was established in a “Federal Register” notice (56 FR 67666) published December 31, 1991. The ninth payment group amount ($1,150) was assigned to only one procedure, CPT code 50590, extracorporeal shock wave lithotripsy (ESWL). However, a court order issued March 12, 1992, has stayed the Group 9 payment rate until the Secretary publishes all information relevant to the setting of the ESWL rate, receives comments, and publishes a subsequent final notice. This has not yet been completed.

In a previous instruction (Transmittal 1435), CMS advised carriers to make payment to ASCs for ESWL services furnished after January 29, 1992, and through the date when the ASC received notice from the carrier of the court order staying the Group 9 payment rate. This was a temporary measure to avoid penalizing ASCs that furnished ESWL services in accordance with the December 31, 1991, "Federal Register" notice and that could not have been expected to know that the March 12, 1992, court order set aside the ESWL provisions of that notice. Carriers do not make Medicare payment for ESWL as an ASC procedure when such services were furnished after the date that the carrier advised an ASC of the court order.

However carriers are instructed to retain all ASC claims for ESWL with a service date after January 29, 1992, and before the date when they notified about the court order. It may be necessary to retrieve these clams for further action at some later date.

50 - ASC Procedures for Completing the Form CMS-1500

(Rev. 1, 10-01-03)

B3-4020.3, PM AB-00-28

The Place of Service (POS) code is 24 for procedures performed in an ASC.

Type of Service (TOS) code is "F" (ASC Facility Usage for Surgical Services) is appropriate when modifier SG appears on an ASC claim. Otherwise TOS "2" (surgery) for professional services rendered in an ASC is appropriate.

Modifier - TC is required unless the code definition is for the technical component only.

60 - Medicare Summary Notices (MSN)

(Rev. 1, 10-01-03)

Standard MSN messages apply.

70 - Ambulatory Surgical Center (ASC) HCPCS Additions, Deletions, and Master Listing

(Rev. 1, 10-01-03)

PM AB-03-032

The CMS Division of Data Systems (DDS) releases the ASC HCPCS, additions, deletions, and master listing files of ASC codes on a periodic basis. Instructions on how to retrieve these files from the CMS mainframe telecommunications system are also published on the same periodic basis. The Office of Information Services (OIS) announces the dates that the files are available.